

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/03/2012
FORM APPROVED
OMB NO. 0938-0391

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|--|--|--|--|---|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 11/29/2012 | |
| NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 000 | <p>INITIAL COMMENTS</p> <p>This visit was for Investigation of Complaints IN00119483 and IN00119761.</p> <p>Complaint IN00119483- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00119761- Unsubstantiated due to lack of evidence.</p> <p>Survey dates: November 28 and 29, 2012</p> <p>Facility number: 000449 Provider number: 155568 AIM number: 100290350</p> <p>Survey team: Teresa Buske RN -TC Mary Weyls RN Laura Brashear RN</p> <p>Census bed type: SNF/NF 70 Total 70</p> <p>Census payer type: Medicare 11 Medicaid 49 Other 10 Total 70</p> <p>Sample: 12</p> <p>Williamsport Nursing and Rehabilitation was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00119483 and IN00119761.</p> | | | F 000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 000 | Continued From page 1 Quality review 11/30/12 by Suzanne Williams, RN | | | F 000 | | | |